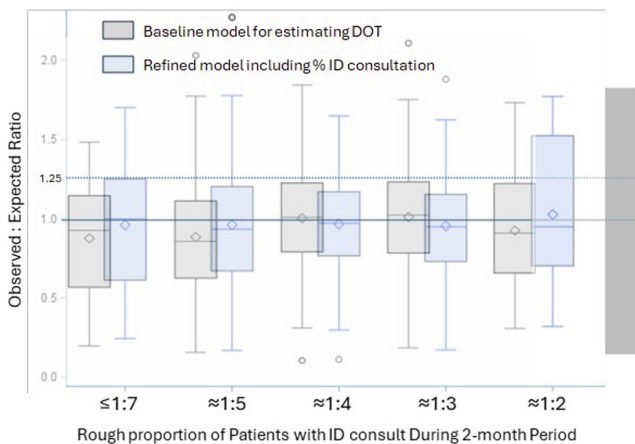


consultant during inpatient stay; median consultation density varied among providers by facility (19%-26%, Figure 1). Multivariate models (accounting for sepsis, UTI, renal disease) estimated significantly increased DOT for hospitalists having  $\sim 1:3$  (+3.4 DOT, 95% CI 0.9 – 5.9) or  $1:4$  (+2.7 DOT, 95% CI 0.4-5.0) patients with ID consults compared to hospitalists with fewer than  $\sim 1:7$  with an ID consult; however the effect was not significant in other strata and not linear (Table 1). Calculating the distribution of OERs both before and after adjusting for consult density resulted in small changes in OERs (Figure 1b). **Discussion:** The frequency of ID consults affected hospitalists' BSHO-DOT in a non-linear fashion. Impact of ID consultation on prescribing metrics should be considered in building credibility of stewardship prescribing performance metrics.

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Figure 2. Distribution of observed to expected ratios for hospitalists, by proportion of patients having Infectious Disease Consultation, both before (grey) and after (blue) adjusting for impact of ID consultation in the predictive models



#### Presentation Type:

Oral Presentation

**Subject Category:** Antibiotic Stewardship

#### Relationship between Hospital Characteristics and Reported Feasibility and Implementation of Antibiotic Stewardship Interventions

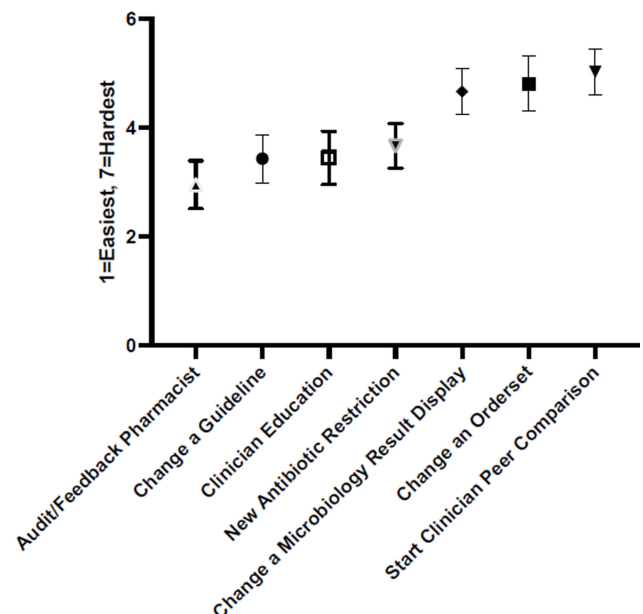
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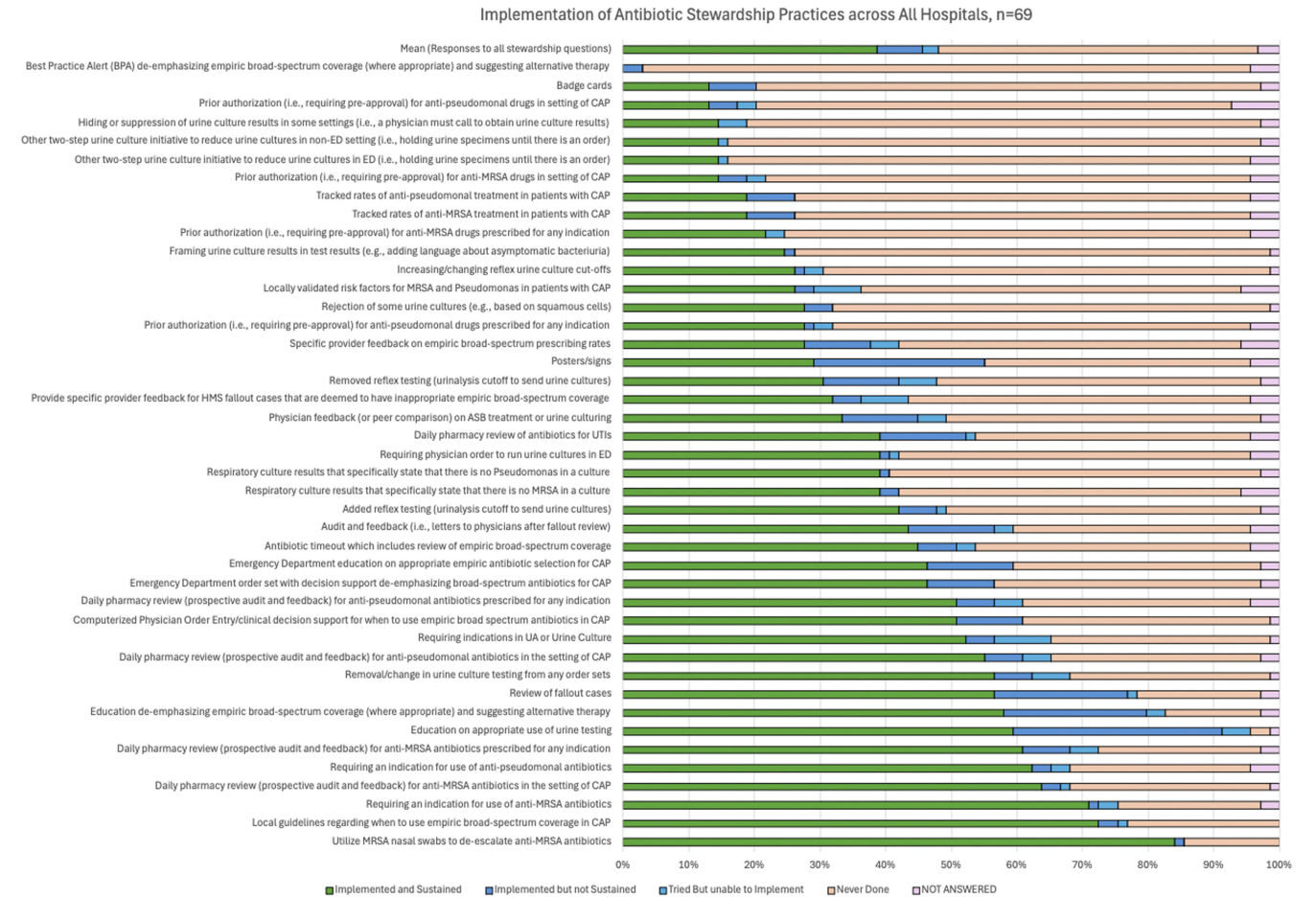
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**Background:** Hospital antibiotic stewardship programs (ASPs) are essential for reducing unnecessary antibiotic use and combating antimicrobial resistance. While many ASP interventions have been described, their feasibility and sustainability remain unclear, particularly for smaller hospitals with limited informatics resources. This study aimed to assess the feasibility and sustainability of common ASP interventions and

examine the impact of hospital bed size on sustainability. **Methods:** A cross-sectional survey was conducted between April and May 2023 across 69 hospitals in Michigan participating in the Michigan Hospital Medicine Safety Consortium, representing both large (>200 beds) hospitals. Quality improvement or antimicrobial stewardship staff from each hospital ranked the feasibility of 7 common antibiotic stewardship interventions on a scale from 1 (easiest) to 7 (hardest). Respondents were then asked to report their status with 43 individual stewardship interventions as: a) implemented and sustained, b) implemented, but not sustained, c) tried but unable to implement, or d) never done. We used descriptive statistics and Fisher's exact tests to compare reported intervention feasibility and implementation by hospital bed size (small vs. large). **Results:** All 69 hospitals responded to our survey (100% response rate). Across all hospitals, increasing audit and feedback by pharmacists was reported as the easiest new intervention to implement, whereas starting clinician peer comparison was reported as the hardest (Figure 1). Hospitals had implemented and sustained multiple stewardship interventions with substantial variation by intervention (Figure 2). Reported feasibility of the 7 common stewardship interventions did not significantly differ between large and small hospitals. However, small hospitals had significantly higher implementation of five antibiotic stewardship interventions: removal or change in order sets in urine culture testing (implemented by 73.1% of small hospitals vs. 46.3% of large hospitals;  $p=0.04$ ), two-step urine culture initiative to reduce unnecessary testing (27% vs. 7%;  $p=0.04$ ), Emergency Department order set with decision support de-emphasizing broad-spectrum antibiotics for CAP (77% vs. 48%;  $p=0.02$ ), daily pharmacy review of antibiotics for UTIs (58% vs. 30%;  $p=0.04$ ), and daily pharmacy review of anti-pseudomonal antibiotics for CAP (73% vs. 46%;  $p=0.04$ ). **Conclusions:** Feasibility and implementation of ASP interventions varied widely, with most interventions sustained once implemented. Technical solutions were 26.4% more likely to be sustained than adaptive ones. Small hospitals showed higher implementation rates for several interventions, potentially due to smaller

#### Difficulty to Implement Change (All Hospitals) Mean 95%(CI)





patient populations and fewer administrative barriers. Hospitals should tailor ASP priorities to their local context, focusing on feasible and sustainable interventions.

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**Presentation Type:**  
Oral Presentation  
**Subject Category:** Antibiotic Stewardship  
**US Adults’ Perspectives on Antibiotic Durations and Adherence to Therapy for Bacterial Respiratory Infections**  
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**Background:** Calls within the clinical community for revising guidance on the appropriate durations of antibiotic therapy (i.e., shorter is better) and adherence (i.e., no longer advising to always finish a course), reflect important gains in evidence-based prescribing. However, changing medical guidance can have negative public effects (e.g., frustration, distrust, and disengagement) when not communicated in ways that resonate with patients. To inform efforts to effectively communicate evolving evidence on appropriate antibiotic use, we examined US adults’ perceptions and preferences regarding antibiotic durations and adherence. **Methods:**

From March to April 2024, we invited US adults, aged ≥18 years, to an online survey about antibiotics. Question topics included durations of antibiotic therapy, adherence to a prescribed course of antibiotics, and demographic characteristics. **Results:** Table 1 shows the characteristics of the 1,476 respondents [completion=89%]. Most respondents reported they preferred to take a longer course of antibiotics (≥7 days) than a shorter one (3-5 days) for a bacterial respiratory infection (60.4% vs. 39.5%) and rated longer courses as both safer and more effective (Table 2). In open-text questions, respondents who preferred shorter courses described a general aversion to medication and concerns about side effects and resistance, whereas those who preferred longer courses saw them as familiar and a ‘better safe than sorry’ approach, associating longer durations with greater efficacy. In addition, 88.4% of respondents agreed that ‘it is important to always finish a prescribed course of antibiotics, even if you start to feel better’ and had either been told this by a medical professional (76.3%) or seen this guidance in a public health message (61.2%). Conversely, only 17.5% said they had ever been told they could stop taking antibiotics early. Preference for longer antibiotic courses was associated with older age, trusting their doctor’s advice about antibiotic therapy durations, having been told by their doctor to ‘always finish a course of antibiotics’, less worry about antibiotic side effects, discomfort about potentially being asked by a clinician to stop taking antibiotics when they start to feel better, and perceiving the clinician suggesting that as less competent. **Conclusions:** Many US adults prefer longer durations of antibiotic therapy for respiratory infections than are likely necessary. Almost all survey respondents believed it important to always finish a course and many were uncomfortable with advice to the contrary. These findings highlight the need for evidence-